Request for Restrictions on Use or Disclosure of Protected Health Information

Date:_____
Name:_____

I. Request for Restriction

I hereby understand that Kentucky Employees Health Plan (the "Plan") may use and disclose protected health information (PHI) about me for purposes of health care treatment, payment and health care operations without my authorization or opportunity to agree or object. I request to restrict use and disclosure of PHI regarding treatment, payment and health care operations about me, or to restrict disclosures to family members, relatives, friends or other persons identified by me who are involved in my care or payment for that care, in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

The Department of Employee Insurance only maintains demographic protected health information which includes personal identifiers, enrollment, eligibility, dependents and qualifying event information. The third-party claims administrator (Humana) and third-party pharmacy benefits manager (Express Scripts) maintain medical condition and treatment protected health information. The third-party administrator will have a separate HIPAA Authorization and Release Form.

(a) I request that the restrictions described below apply to the following information:_____
_____
_____
_____

(b) I request that the use and disclosure of the information described in (a) above be restricted in the following manner:_____
_____
_____

(c) I request that my PHI not be disclosed to the following individuals or entities:_____
_____
_____

I understand that the Plan is not required to agree to this restriction.

II. Other Important Information

I understand that if the Plan agrees to this restriction, either the Plan or I may terminate this restriction at any time. If the Plan informs me that it is terminating its agreement to a restriction, the termination of the restriction is only effective with respect to PHI created or received after the Plan informs me of the termination.

I understand that if restricted PHI must be used or disclosed to provide emergency treatment for me, then this restriction is void. I understand that if a restriction is agreed to by the Plan, it is not

effective to prevents uses or disclosures required by the Secretary of the U.S. Department of Health and Human Services to investigate the Plan's compliance with HIPAA or uses or disclosures that are otherwise required by law. I understand that if a restriction is not specifically listed above and agreed to in writing by the Plan, it will not be effective.

III. Signature of Member or Member's Representative

_____ _____

Signature of member or member's representative **Date**

(Form MUST be completed before signing.)

Printed name of the individual's personal representative:

_____

Relationship to the individual, including authority for status as representative:

_____

_____

Signature

_____

Printed